ASSISTED LIVING RESIDENCE
PERSONAL DATA and RESIDENT EVALUATION

Facility Name: _____
Resident's Name: _____ Date of Evaluation: _____

Reason for evaluation: ☐ Pre-admission ☐ Annual ☐ 6-Month Review of ISP ☐ Change in physical/functional status.

ADMISSION / DISCHARGE INFORMATION

Date: _____ **County:** _____

Admitted from: ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH**

Other (specify): _____

Address Admitted from (Street, City, State, Zip): _____

Resident's Admission Sponsor (if any): _____

Discharge Date: _____ **Discharge to:** ☐ **Own Home** ☐ **Hospital** ☐ **NH** ☐ **OMH**

☐ **Other (Specify):** _____

Address Discharged to (Street, City, State, Zip Code): _____

Reason for Discharge: _____

SECTION 1: PERSONAL DATA

Date of Birth: ____/___/____ (Month / Day / Year) Gender: ☐ M ☐ F SSN: _____

Status: _____ Married _____ Single _____ Divorced _____ Widowed _____ Partner

NOTIFY IN CASE OF EMERGENCY

Name _____

Relationship _____

Telephone Number (s) _____

Address _____

City _____ State _____ Zip _____

ATTENDING PHYSICIAN

Name _____

Address _____

City _____ State _____ Zip _____

OTHER HEALTH CARE PROVIDERS

Name _____

Specialty _____ Phone: _____

Address _____

City _____ State _____ Zip _____

Name _____

Specialty _____ Phone: _____

Address _____

City _____ State _____ Zip _____

HEALTH INSURANCE

Insurer _____ ID # _____

Medicaid No. _____

Medicare No. _____

Prescription Drug Plan (if any) _____

Plan ID # _____

Other Health Care Coverage _____

_____

Pharmacy(ies) _____

_____

Phone _____ Phone _____

Address(es) _____

_____

City _____ State _____ Zip _____

AREA HOSPITAL / CLINIC OF CHOICE

Name _____

Address _____

_____

Facility Name: _____
Resident's Name: _____ Date of Evaluation: _____

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as: _____

Address (if different from ALR): _____

Resident's Representative: _____
Relationship: _____
Address: _____
_____
Phone: **Home** _____
Work _____
Cell _____

Significant Other: _____
Relationship: _____
Address: _____
_____
Phone: **Home** _____
Work _____
Cell _____

Significant Other: _____
Relationship: _____
Address: _____
_____
Phone: **Home** _____
Work _____
Cell _____

Significant Other: _____
Relationship: _____
Address: _____
_____
Phone: **Home** _____
Work _____
Cell _____

Residential Background (born/raised, lived most of life): _____

_____

Occupational/Educational Background: _____

_____

Religious Affiliation (if any): _____ **Place of Worship:** _____ **Phone:** _____

Health Care Proxy: ☐ Yes ☐ No _____ **DNR**: ☐ Yes ☐ No
(Name)

Power of Attorney: ☐ Yes ☐ No _____ **Living Will:** Yes ☐ No ☐
(Name)

Burial Instructions: _____

_____

Can the individual speak, read and/or write in English? ☐ Yes ☐ No If No, indicate dominant language: _____

Verbal Expression/Speech (check all that apply):

Easily Understood	☐ Yes	☐ No	Difficulty finding words or expressing self	☐ Yes	☐ No
Slurred or mumbled speech	☐ Yes	☐ No	Understands directions	☐ Yes	☐ No

Other sensory impairments observed (check all that apply):

☐ Hearing ☐ Vision Comment(s): _____

_____

Facility Name: _____
Resident's Name: _____ Date of Evaluation: _____

SECTION 3: CUSTOMARY ROUTINE

Sleeping routine: **Preferred wake up time:** _____ **Napping routine:** _____
Preferred bedtime: _____ **Nighttime sleep pattern:** _____

Comments: _____

_____

Bathing routine: **Prefers** ☐ **Bath** ☐ **Shower** **Frequency:** _____

Comments: _____

_____

Eating routine: **Food preferences:** _____ _____ _____
Food dislikes: _____ _____ _____

Comments: _____

_____

Daily Events: (check all that apply)

☐ Goes out _____days a week (Specify 1 – 7)
☐ Stays busy with hobbies, reading, fixed daily routine
☐ Spends most time alone
☐ Contact with relatives/close friends _____days per week (Specify 1 – 7)
☐ Spends most time watching TV
☐ Usually attends church, synagogue etc.
☐ Prefers small group activities
☐ Prefers large group activities

Comments: _____

_____

SECTION 4: CONTINENCE STATUS/MANAGEMENT

Is the resident continent of urinary function? (Obtained from Med. Eval. DOH - 3122) ☐ Yes ☐ No

Is the resident continent of bowel function? (Obtained from Med. Eval. DOH - 3122) ☐ Yes ☐ No

IF ANSWER IS "NO" TO EITHER QUESTION, COMPLETE THIS SECTION, AS APPROPRIATE.

Urinary Incontinence		**Bowel Incontinence**	
☐ Less than once a week ☐ Several times a week ☐ Daily	☐ Day Only ☐ Night only ☐ Day and night	☐ Less than once a week ☐ Several times a week ☐ Daily	☐ Day only ☐ Night only ☐ Day and night
Current management techniques		**Current management techniques**	
☐ Prompting/reminding defers incontinence ☐ Timed voiding defers incontinence ☐ Uses incontinence pads/adult diapers: ☐ Day only ☐ Night only ☐ Day and night Catheter (specify type) _____ Comments: _____ _____ Self-manage continence? ☐ Yes ☐ No		☐ Uses incontinence pads/adult diapers: ☐ Day only ☐ Night only ☐ Day and night Comments: _____ _____ _____ Self-manage continence? ☐ Yes ☐ No	

Facility Name: _____
Resident's Name: _____ Date of Evaluation: _____

SECTION 5: PHYSICAL FUNCTION

TASK	LEVEL OF ASSISTANCE	COMMENTS
Eating: (Ability to feed self meals and snacks)	☐ **Independent:** Able to feed self independently with or without assistive device. ☐ **Intermittent Assistance:** Requires minimal, intermittent supervision and/or assistance. ☐ **Continual Assistance:** Requires constant assistance and/or supervision throughout meal. ☐ **Total Assistance:** Unable to feed self, needs to be fed. Unable to take nutrients orally, requires enteral nutrition.	Dentures Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No Chewing difficulties ☐ Yes ☐ No Difficulty swallowing ☐ Yes ☐ No Modified consistency ☐ Yes ☐ No Specify _____ **Comments:**
Ambulation: (Ability to safely walk and move about once in a standing position)	☐ **Independent:** Walks and climbs and descends stairs independently with or without assistive device. ☐ **Intermittent Assistance:** Walks and climbs and descends stairs with minimal, intermittent assistance and/or supervision. ☐ **Continual Assistance:** Walks and climbs and descends stairs with constant supervision and/or assistance. ☐ **Total Assistance:** Chairfast or bedfast. Requires total assistance for mobility.	☐ Wheelchair ☐ Walker ☐ Quad cane ☐ Cane ☐ Other: _____ Falls within the last 3 months? ☐ Yes ☐ No Frequency #: _____ Injury: _____ **Comments:**
Transferring: (Moving from bed to chair, on/off toilet, in/out of shower or tub)	☐ **Independent:** Able to transfer independently with or without assistive device. ☐ **Intermittent Assistance:** Transfers with minimal human assistance and/or supervision. ☐ **Continual Assistance:** Unable to transfer but can bear weight and pivot when transferred by at least one other person. ☐ **Total Assistance:** Chairfast or bedfast, unable to transfer, pivot, bear weight or turn self in bed.	**Comments:**

Facility Name: _____
Resident's Name: _____ Date of Evaluation: _____

TASK	LEVEL OF ASSISTANCE	COMMENTS
Toileting: (Getting to/from and on/off the toilet, cleansing self after elimination and adjusting clothing)	☐ **Independent:** Able to toilet independently with or without assistive device. ☐ **Intermittent Assistance:** Able to toilet with minimal intermittent assistance and/or supervision. ☐ **Continual Assistance:** Able to toilet with constant assistance and/or supervision. ☐ **Total Assistance:** Unable to toilet. Requires total assistance with toileting.	**Ostomy** ☐ Yes ☐ No **Comments:**
Bathing: (Getting in and out of tub or shower, washing and drying entire body)	☐ **Independent:** Able to bathe or shower independently with or without assistive device. ☐ **Intermittent Assistance:** Able to bathe or shower w/minimal intermittent assistance and/or supervision. ☐ **Continual Assistance:** Able to bathe or shower with constant assistance and/or supervision. ☐ **Total Assistance:** Unable to use shower or tub. Bathed in bed or at bedside.	**Comments:**
Dressing: (Getting clothes from closets and drawers, dressing and undressing upper/lower body including buttons, snaps, zippers, socks and shoes)	☐ **Independent:** Able to dress and undress independently with or without assistive device. ☐ **Intermittent Assistance:** Able to dress and undress with minimal, intermittent assistance and/or supervision. ☐ **Continual Assistance:** Requires assistance throughout the dressing and undressing process. ☐ **Total Assistance:** Requires another person to dress and undress upper and lower body.	**Comments:**
Grooming: (Washing face, hair care, shaving, teeth/denture, fingernail care, eyeglasses care)	☐ **Independent:** Able to groom self independently with or without assistive device. ☐ **Intermittent Assistance**: Requires grooming utensils to be set up and placed within reach. ☐ **Continual Assistance:** Requires assistance throughout the grooming process. ☐ **Total Assistance:** Depends entirely upon someone else for grooming.	**Comments:**
Transportation: (Physical and mental ability to safely use a car, taxi, or public transportation [bus, train, subway])	☐ **Independent:** Able to independently drive a regular or adapted car; *OR* uses a regular or handicap accessible public bus, train or subway. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to ride in a car only when driven by another person; *AND/OR* due to physical, cognitive or mental limitations occasionally requires another person to accompany him/her when using a bus, train or subway. ☐ **Continual Assistance:** Able to ride in a car only when driven by another person; *OR* able to use a bus or handicap van, train or subway only when assisted or accompanied by another person. ☐ **Total Assistance:** Unable to ride in a car, taxi, bus or van, and requires transportation by ambulance.	**Comments:**

Facility Name: _____
Resident's Name: _____ Date of Evaluation: _____

TASK	LEVEL OF ASSISTANCE	COMMENTS
Laundry: (Ability to do own laundry – to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand)	☐ **Independent:** Able to independently take care of all laundry tasks. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to do only light laundry, such as minor hand wash or light washer loads. Needs assistance with heavy laundry, such as carrying large loads of laundry. ☐ **Continual Assistance:** Due to physical, cognitive or mental limitations, needs continual supervision and assistance to do any laundry. ☐ **Total Assistance:** Unable to do any laundry.	**Comments:**
Housekeeping: (Ability to safely and effectively perform light housekeeping and heavier cleaning tasks)	☐ **Independent:** Able to independently perform all housekeeping tasks. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently; *AND/OR* able to perform housekeeping tasks with intermittent assistance or supervision from another person. ☐ **Continual Assistance:** *Unable* to consistently perform any housekeeping tasks unless assisted by another person throughout the process. ☐ **Total Assistance:** Unable to effectively participate in any housekeeping tasks.	**Comments:**
Shopping: (Ability to plan form, select and purchase items in a store and to carry them home or arrange delivery)	☐ **Independent:** Able to plan for shopping needs and independently perform shopping tasks, including carrying package. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to do only light shopping and carry small packages, but needs someone to do occasional major shopping. ☐ **Continual Assistance:** *Unable* to go shopping alone, but can go with someone to assist; *OR* unable to go shopping but is able to identify items needed, place orders, and arrange for home delivery. ☐ T**otal Assistance:** Needs someone to do all shopping and errands.	**Comments:**
Ability to use a Telephone: (Ability to answer the telephone, dial numbers, and *effectively* use the telephone to communicate)	☐ **Independent:** Able to dial numbers and answers calls appropriately and as desired. ☐ **Independent:** But requests facility perform task. ☐ **Intermittent Assistance:** Able to use a specially adapted telephone (i.e., large numbers on the dial pad, teletype phone for the deaf) and call essential numbers; able to answer the telephone and carry on a normal conversation but has difficulty with placing calls; able to answer the telephone only some of the time or is able to carry on only a limited conversation. ☐ **Continual Assistance:** Unable to make calls or answer the telephone at all, but can listen if assisted with equipment. ☐ **Total Assistance:** Totally unable to use the telephone. Requires someone else to make calls.	**Comments:**

Facility Name: _____
Resident's Name: _____ Date of Evaluation: _____

SECTION 6: COGNITIVE IMPAIRMENT SCREEN

Cognitive Functioning: Individual's current level of alertness, orientation, comprehension, concentration and immediate memory.

Response:

What is today's date? (correct, if within 2 days)	☐ Correct	☐ Incorrect
What day of the week is today:	☐ Correct	☐ Incorrect
How old are you?	☐ Correct	☐ Incorrect
When were you born?	☐ Correct	☐ Incorrect

Behaviors of Note (check all that apply):

☐ Wanders Day / Night
☐ Sleep disturbance
☐ Confused
☐ Agitated (repeated vocalizations, screaming, shouting, complaining, moaning, cursing, fidgeting, etc.)
☐ Depressive Feelings
☐ Anxious
☐ Withdrawn/ Refuses to Socialize

Overall Cognitive Functioning (check all that apply):

☐ Is alert and oriented, comprehends verbal questions and commands and has accurate recall

☐ Requires prompting and redirection, on occasion, to complete tasks

☐ Has occasional fluctuation in orientation, memory/alertness

☐ Has significant memory loss and is disoriented to person, place and/or time

This screen includes indicators, which are often related to cognitive impairment. This is a screen ONLY and is intended to assist the residence in determining if an individual is appropriate for care in an ALR and/or if the individual should be referred to his/her physician for consultation and/or further evaluation or treatment.

Comments: _____

_____

_____

_____

Facility Name: _____
Resident's Name: _____ Date of Evaluation: _____

SECTION 7: Admission / Level of Care

Current level of care: ☐ Pre-admission ☐ ALR / EHP / AH ☐ Enhanced ALR ☐ Special Needs ALR

ADMISSION DECISION ☐ Not Accepted

ACCEPTED TO: ☐ ALR / AH / EHP ☐ Enhanced ALR ☐ Special Needs ALR

For new admissions, the following documents were provided to the applicant at, or prior to, the admissions interview:

_____ Consumer Information Guide

_____ Copy of the admission agreement

_____ Copy of the statement of resident rights

_____ Copy of any facility regulations relating to resident activities, office and visiting hours and like information

_____ Information about the Long-Term Care Ombudsman Program and listing of legal services or advocacy agencies, if made available by the Department

_____ Personal Allowance Protections (SSI and TA recipients only)

_____ Most recent Statement of Deficiencies (shown to applicant)

Signature(s) of ALR staff participating in this evaluation.

Name: _____ Title: _____ Date: _____

Name: _____ Title: _____ Date: _____

Name: _____ Title: _____ Date: _____

Signature of Administrator/Case Manager/or ISP Planner: _____ **Date:** _____

Signature of Individual/Resident: _____ **Date:** _____

Signature of Resident Representative: _____ **Date**: _____

Name(s) of others participating in this evaluation.

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____